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The Role of Alcohol in the Lives and Deaths of Children and Youth In British Columbia

A special report written by:

The Children's Commission

Province of British Columbia

October, 2001

Executive Summary

Alcohol is one of the most commonly used drugs within our society. Most adults drink and many consume alcohol regularly. Despite a legal drinking age of 19 in British Columbia, few adolescents wait until then to begin to use alcohol. Both the direct and indirect effects of alcohol can lead to adverse health and safety risks for children and youth. The purpose of this report is to explore the influence of alcohol in the lives and deaths of children in British Columbia, and to explore ways in which risks might be reduced and future deaths might be prevented.

Established in 1996, British Columbia's Children's Commission has a statutory mandate to collect information on all deaths of children and youth under the age of 19 years. The Commission undertakes comprehensive child fatality reviews to determine the adequacy of services to the child or youth, and to examine public health and policy matters. The review process is conducted by trained investigators and involves interviews with key informants and a review of documents and records produced by agencies and organizations that were involved in service provision. Each case is then reviewed by an independent Multi-disciplinary Team of expert advisors. The sample for this study consists of 558 publicly released reviews, 418 completed since October 1996 and 140 "historical" cases where the child died prior to October 1996.

In reviewing the 558 fatalities a series of questions were posed. These questions pertained to how these children died, whether alcohol was present at the time of death and if it there was a history of alcohol use either by the deceased child or a person who was involved in the child's life in some way.

Of the total of 358 male and 200 female deaths reviewed, 114 children were of aboriginal origin and 64 were children in care (CIC). The most common classification of death was accidents, followed by natural causes, SIDS, suicide and homicide. Key findings of the study include:

- Alcohol has a profound presence in the lives and deaths of these children. It is present at the time of death in 2 out of 5 MVA, and 1 out of 3 suicides and drownings. Alcohol also played an important role historically in the lives of many of the cases we reviewed.

- MVAs continue to take many young people's lives. While it was most often the driver of the primary vehicle that was drinking, it was the passenger of that vehicle who was most likely to die.

- Prenatal exposure to alcohol occurred in approximately 1 in 10 cases we reviewed. Approximately 37% of deaths of children who had prenatal alcohol exposure, were SIDS deaths.

- The impact of alcohol especially on children in care as well as Aboriginal children is particularly profound. The impact occurs earlier, results from a number of factors and is associated with tragic outcomes.

Table of Contents

I. Introduction and Purpose..... 1

II. The Child Fatality Review Process..... 6

III. Methods..... 8

A) Case Selection
B) Research Questions
C) Limitations

IV. Findings..... 11

A) General Demographics
B) Broad Classifications of All Deaths
C) Alcohol Use
D) Evidence of FAS/pFAS or prenatal exposure
E) Classifications of Death
1) Motor Vehicle Accidents
2) Drowning
3) Suicide
4) Homicide
5) Sudden Infant Death Syndrome
6) Summary of Findings

V. Children's Commission Recommendations – Alcohol Related..... 30

A) Child Protection/ Legislation
B) Prevention and Early Intervention
C) Staff/Caregiver Training
D) Public Awareness/Education
E) Program/Service Delivery

VI. Key Findings and Policy Implications..... 34

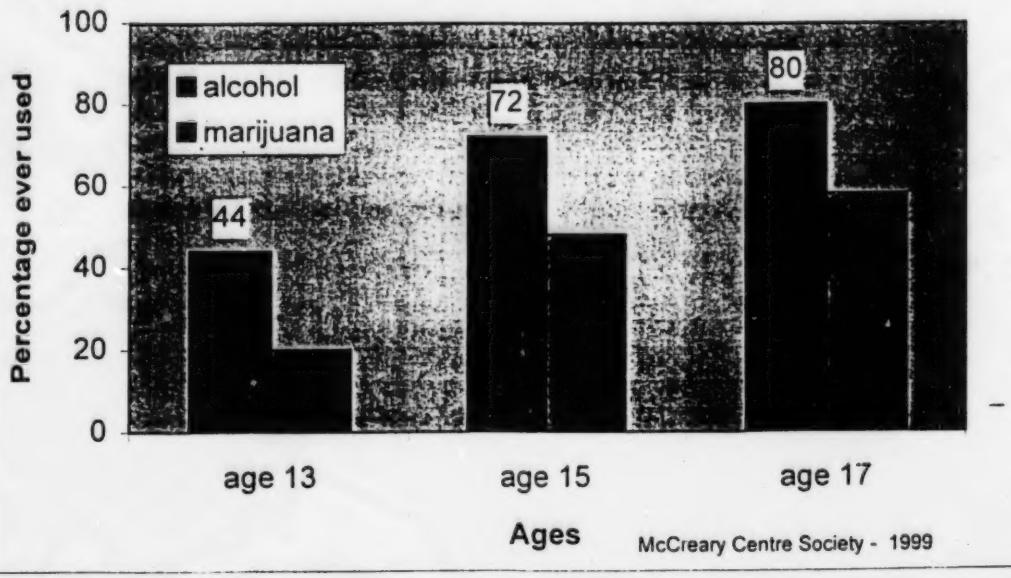
References 36

I. Introduction and purpose

Alcohol use is undeniably a visible and acceptable part of Canadian society. According to the 1999 National Population Health Survey, approximately 2/3 of men and 2/5 of women above the age of 15 drink alcohol at least once per month. Of those people who consume alcohol, about 40% of men and 20% of women report drinking 5 or more drinks on at least one occasion during the past year. Although the use and availability of alcohol is subject to some controls in our society, its use remains pervasive and therefore it comes as no surprise that alcohol consumption is common, among those under the legal drinking age of 19.

The initial use of alcohol frequently occurs before or during early adolescence (Figure 1). A study completed by the McCreary Centre Society (1999) on British Columbia youth showed that even by age 13, 44% of youth reported consuming alcohol within the last year. By the age of 17, this figure climbs to 80% of youth reporting alcohol consumption in the last year. More importantly, 40% of youth in this survey reported engaging in heavy drinking in the past month. Heavy drinking is defined as 5 or more drinks in two hours.

Figure 1. Rates of alcohol and marijuana use by BC youth - 1999



Both the direct and indirect effects of alcohol can lead to adverse health and safety risks for children and youth. Alcohol has been implicated in child deaths due to drowning, falls, motor vehicle accidents, and homicides and has been implicated as a risk factor in many suicides and SIDS fatalities. "The younger a child initiates alcohol and other drug use the higher the risk for serious health consequences and adult substance abuse" (Belcher H., & Shinitzky, H. 1998)

The Children's Commission investigates all unexpected deaths among children and youth (under the age 19) in the province of British Columbia. As well the Commission investigates all deaths of children and youth that received services from the Ministry of Children and Family Development (MCFD) or were Children-in-Care (CIC). As a result the Commission is in a unique position to explore the role that alcohol has had in the lives and deaths of children and youth who have died in this province. This report reflects the findings of a study conducted by the Commission on the influence of alcohol in the lives and deaths of children and youth in British Columbia.

Numerous charts, figures and tables on children and youth who have died are contained in this report. By looking across a number of circumstances in which children have died, common factors observed in the lives and deaths of these children can be identified. This can be accomplished by developing the kinds of charts and tables presented in this report. However as this information is being presented we need to be respectful of the individual suffering and grief each of these children leave behind as a result of their death.

"Statistics are numbers with the tears wiped off" (anonymous)

The purpose of this report is to:

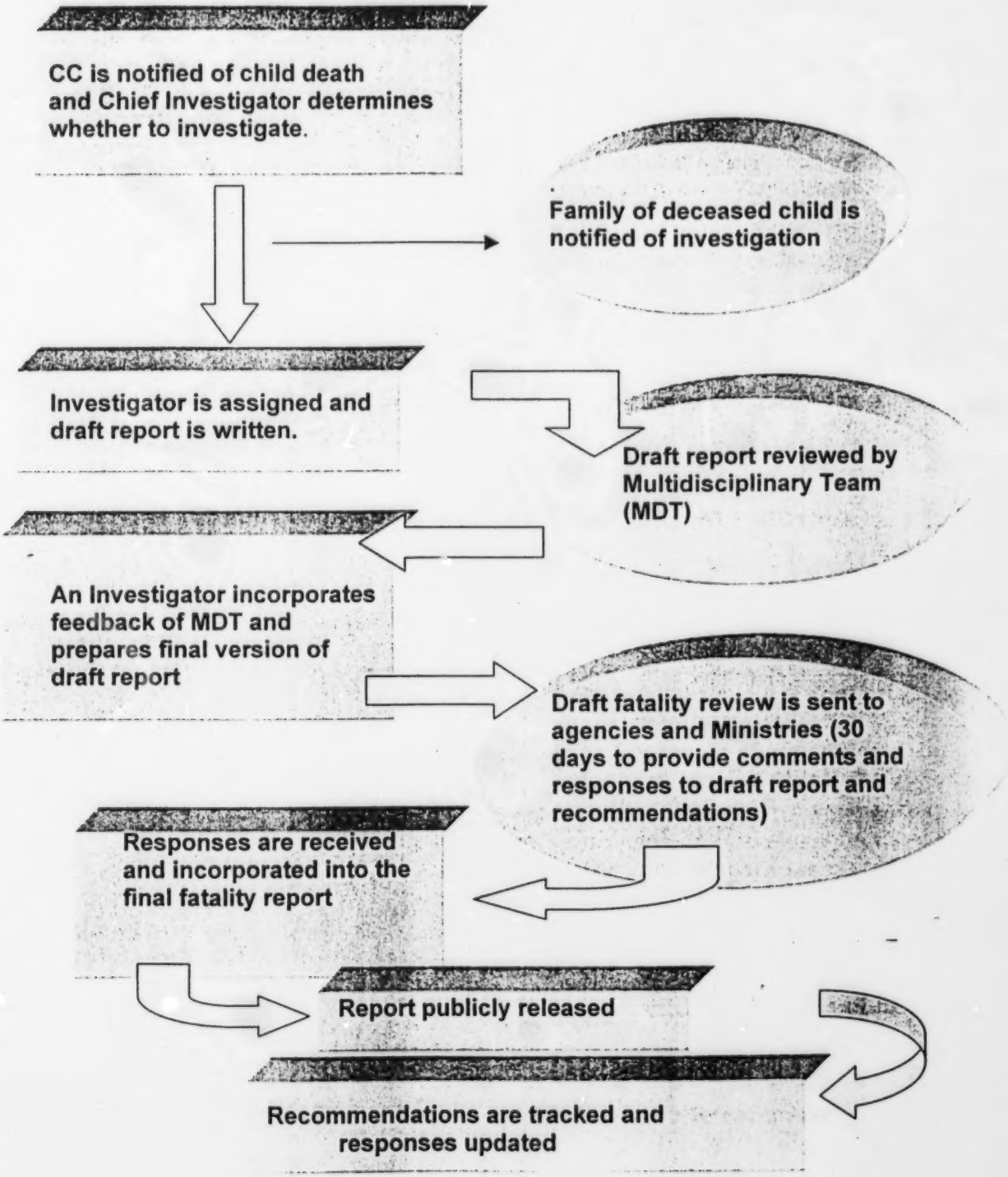
- to explore the influence that alcohol has on the lives and deaths of children and youth;
- to present an overview of the recommendations made by the Children's Commission as they relate to alcohol;
- to discuss the public policy implications of the findings.

II. The Child Fatality Review Process

Established in 1996, British Columbia's Children's Commission has a statutory mandate (Bill 23 - Children's Commission Act) to collect information on all deaths in the province of children and youth under the age of 19 years. The Commission undertakes comprehensive child fatality reviews to determine the adequacy of services to the child or youth, and to examine public health and policy matters. The review process is conducted by trained investigators and involves interviews with key informants and a review of documents and records produced by agencies and organizations that were involved in service provision (see Figure 2.)

Once the draft fatality report is reviewed and approved by the Chief Investigator it is examined by a Multidisciplinary Team (MDT) of expert advisors. The Team is comprised of experts in law enforcement, medicine, services to child welfare, aboriginal children, education, and child abuse. A representative from the coroner's office also participates on the MDT. Draft reports are forwarded to agencies and ministries whose responsibilities or interests pertain to the content and recommendations of the report for comment and response to the recommendations. Final revisions are made, all identifiers are removed to protect anonymity and the report is publicly released.

Figure 2. The Child Fatality Review Process


CC is notified of child death and Chief Investigator determines whether to investigate.
Family of deceased child is notified of investigation
Investigator is assigned and draft report is written.
Draft report reviewed by Multidisciplinary Team (MDT)
An Investigator incorporates feedback of MDT and prepares final version of draft report
Draft fatality review is sent to agencies and Ministries (30 days to provide comments and responses to draft report and recommendations)
Responses are received and incorporated into the final fatality report
Report publicly released
Recommendations are tracked and responses updated

III. Methods

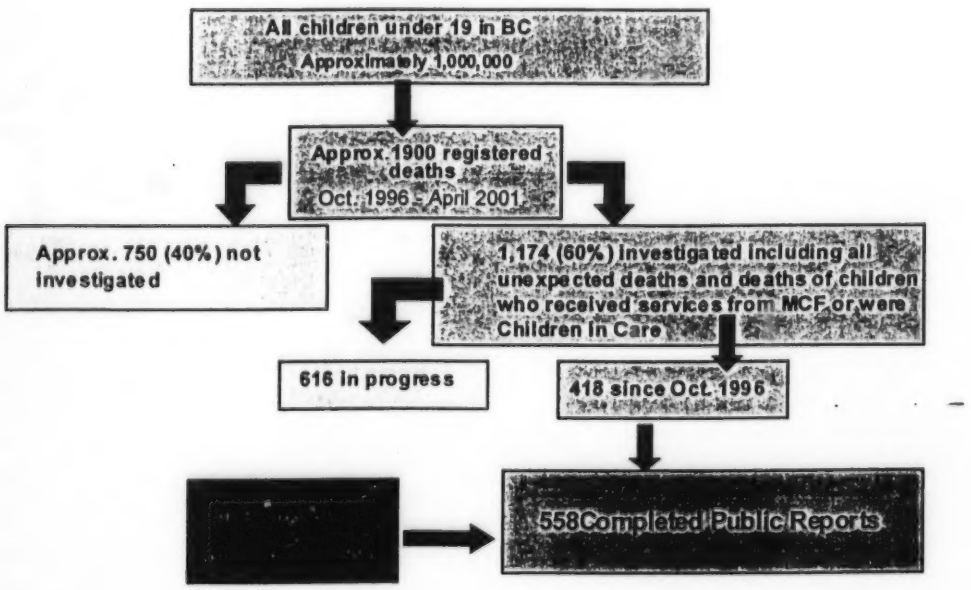
A) Case Selection

There are approximately one million children and youth in the province of BC. During the past 5 years approximately 1900 deaths have been registered. Of these 1900 deaths, the Children's Commission has opened 1,174 formal reviews. Deaths are reviewed if they are unexpected, if the child had received services from the Ministry for Children and Families (MCF) within the past year or if the child was a "child in care" (CIC) at the time of death.

From October 1996 to April 2001, 418 fatality reports were completed and publicly released.

The Commission has also completed 140 reviews on children who had died prior to October 1996. These were children in care or receiving services from the former Ministry of Social Services. Therefore as of April 2001, a total of 558 reports have been published (see Figure 3).

Figure 3. Case Selection


All children under 19 in BC
Approximately 1,000,000
Approx. 1900 registered deaths
Oct. 1996 - April 2001
Approx. 750 (40%) not investigated
1,174 (60%) investigated including all unexpected deaths and deaths of children who received services from MCF or were Children in Care
616 in progress
418 since Oct. 1996
558 Completed Public Reports

B) Research Questions

In reviewing the 558 fatalities we posed the series of questions that appear below. Reports were analyzed within this framework. The questions can be categorized as follows:

1) **General demographics:**
   a) What was the child's age, gender and origin?
   b) Did the child receive services from MCF in the past year?
   c) Was the child a child-in care?

2) **Broad classifications of all deaths**
   a) How was the child's death classified?

3) **Alcohol use:**
   a) Was alcohol mentioned in the report?
   b) Was the child under the influence of alcohol at the time of death?
   c) Did the child/youth have a history of alcohol use?
   d) Did someone else in child's life misuse alcohol?
   e) Who were the other persons in the child's life who misused alcohol?
   f) Were there others under the influence of alcohol at the time of death?

4) **Evidence of FAS or p/FAS, or evidence of prenatal alcohol exposure:**
   a) Did mother drink alcohol while she was pregnant?
   b) Was FAS or p/FAS mentioned in the file?
   c) If FAS or p/FAS was mentioned who was affected?

5) **Classifications of death.**
   There were 5 classifications of death we examined to determine if alcohol was associated with them in any way.

   a) **MVA**
      i) Was a motor vehicle and alcohol involved in the death?
      ii) Who was the person who used alcohol?
      iii) Was the child who died the driver, a passenger or a pedestrian?

   b) **Drowning**
      i) Was a boat and alcohol involved in the child's death?
      ii) Who was the person who used alcohol?
      iii) What was the child doing at the time of death?

   c) **Suicide**
      i) Was alcohol involved in a suicide death?
      ii) Who was the person who used alcohol?

   d) **Homicide**
      i) Was alcohol involved in a homicide?
      ii) Who was the person who used alcohol?

   e) **SIDS**
      i) Was alcohol involved in a SIDS death?
      ii) Who was the person who used alcohol?

Once general demographic information had been collected on all cases, the characteristics surrounding the use of alcohol were determined. This process was initiated by posing the question: *was alcohol mentioned in any way in the fatality report?* Alcohol use was identified as follows: a history of alcohol use on the part of the deceased child; alcohol use at the time of the child's death or a history of alcohol use on the part of others connected to the child or the child's death.

Alcohol misuse was recorded if any of the key words associated with alcohol was found including "drinking", "drunk", "intoxicated", or "inebriated". We did not differentiate between the various amounts of alcohol being consumed. The investigators who conduct the fatality reviews stated that when a reference to alcohol appeared in a report it always pertained to misuse or abuse of the product.

Attempts were also made to differentiate between alcohol misuse and other drug use. If the report made no mention of alcohol use and only referred to, for example, marijuana use, then alcohol use would be recorded as "no". If there was evidence of empty alcohol containers or the youth had attended a substance abuse program, this was recorded "likely" use of alcohol. In our data analysis the "yes" and "likely" categories were frequently collapsed together.

Classifications of death were based on the categories used by the BC Coroner's Service. Sudden Infant Death Syndrome (SIDS) deaths were treated as a separate category.

C) Limitations

The Children's Commission does not complete full reviews on all child deaths in the province but rather reviews all unexpected deaths, deaths of children known to MCF, and deaths of CIC. Therefore the ratio of aboriginal children is higher than expected because they are over-represented in the CIC population.

Another limitation includes the timing of when the fatality reports are publicly released. Depending on the amount of time needed to review a fatality some reports may be completed in less time than others. Of the 1900 children who have died since 1996, approximately 40% were not investigated because they didn't meet the investigation criteria, 22% have been completed and publicly released and 37% are in the process of being reviewed. This affects the numbers that appear in different fatality categories. For example, the Commission's data may show a slightly higher number of MVA fatalities in relation to other types of deaths as the investigators may be able to complete these reviews more quickly than other types of fatalities.

Some reports completed in 1996 may not have been done as thoroughly since reporting criteria were being established at that time. Some may contain only limited information on, for example, the history of alcohol use. As well, reviewing the death of a child is an extremely complex process and each investigator may pursue a case in a slightly different way depending on the particulars of that case. Since 1996 clearer criteria for writing reports have been established and therefore consistency in the information collected has been enhanced.

The sample for this study was drawn from the 418 fatalities that have occurred since October 1996 and were publicly released, as well as 140 historical records which were provided to the Children's Commission shortly after its inception. These 140

fatalities occurred prior to October 1996 and consisted of mostly those known to child protection authorities. This therefore inflates the fatality numbers with respect to how many were CIC.

Finally, because of the design for this study, causation cannot be implied. In other words, while alcohol use may have occurred at the time of death or in the histories of some children and youth, this study is limited in its ability to state that this use caused the child or youth's death.

IV. Findings

A) General Demographics

A total of 358 male and 200 female deaths were reviewed. The highest percentage of fatalities fell into two age groups, the youngest age group – the 0 to 4 year olds, and the oldest age group – the 15 to 18 year olds. Figure 4 shows this frequency distribution as a "u" curve. Although both genders follow this same frequency distribution, more males died as compared to females in all age categories.

Figure 4. What were the ages and genders of the children and youth ?

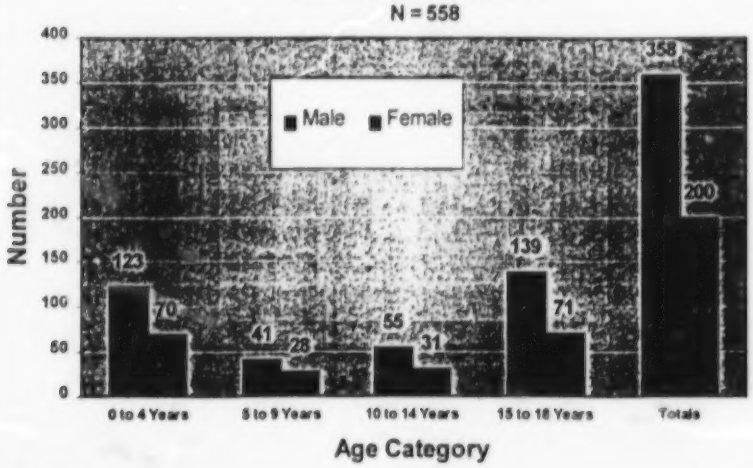


Figure 5 presents the number of aboriginal and non aboriginal children by gender. Approximately 20% (or 114 of the publicly released reports were aboriginal children and youth. Aboriginal children and youth make up approximately 8% of the overall child population in BC, therefore a greater proportion of aboriginal children were found in this study than would be expected. Part of this could be due to the selection bias that

exists (our sample included CIC of which many are aboriginal). As well, previous research has indicated that the rates of aboriginal children dying from SIDS and suicide is greater than in the general population of children (A Report on the Health of British Columbians, 1997).

Figure 5. How many of the children and youth were aboriginal ?

(N= 553, 5 children's orgins were unidentified)

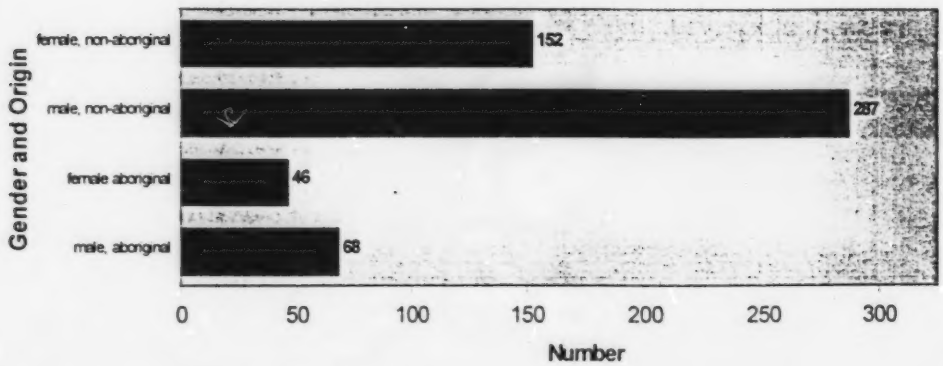


Figure 6. compares the numbers of aboriginal and non-aboriginal cases by age. In both the aboriginal and non-aboriginal groups the same "u" shape of fatality distribution across the age groups occurred. However, in the aboriginal population the highest number of fatalities occurred in the youngest age group 0-4; as compared to the non aboriginal group who had their highest number of fatalities in the oldest age group 15-18.

Figure 6. What were the ages of the Aboriginal and Non Aboriginal Children and Youth who Died?

(N= 553. Non-Aboriginal includes 5 unknown origin)

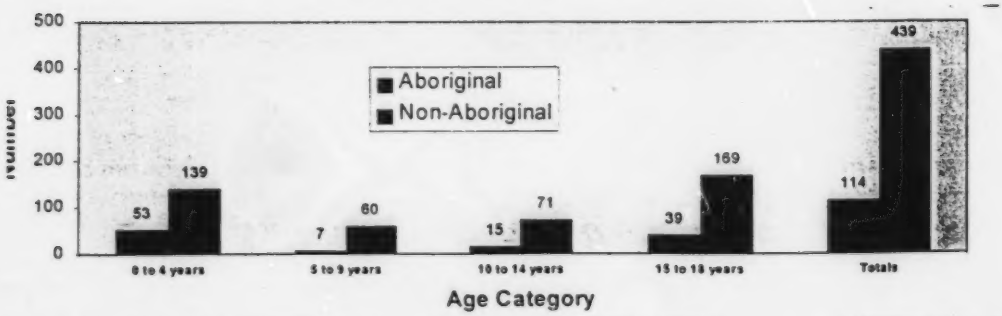
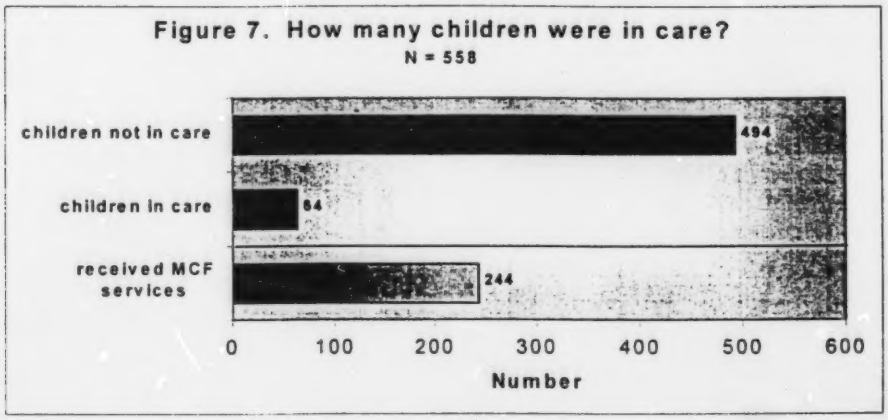


Figure 7. presents the numbers of children and youth who were "in care" at the time of their death as compared to those "not in care". It also presents the numbers of child fatalities that had received services from MCF within the past year before their deaths. Most fatalities involved children "not in care of the ministry" at the time of their death. However, 64 children and youth were "in care" at the time of their death. The number of children and youth who had received services from MCF appear below the dark line – and consists of approximately 45% of the sample. (Note: the numbers of CIC and children who received MCF services are inflated due to the sampling process utilized in this study. See limitations section).



B) Broad Classifications of All Deaths

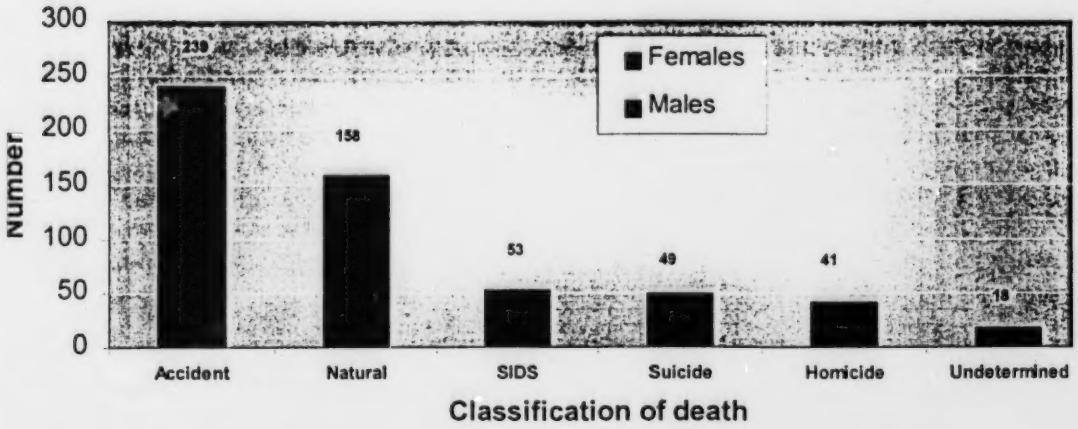
For both genders, as shown below in Figure 8, most of the fatalities occurred as a result of accidents. Accidents are defined as poisoning, drowning, cliff jumping, motor vehicles accidents or any type of vehicle such as trains, boats, or snowmobiles.

The second most common classification of death was due to natural causes. Natural causes consist of illnesses and diseases such as childhood leukemia and cardiovascular diseases.

SIDS, the third most common classification, is technically not a diagnosable classification but rather is the absence of an identifiable pathological condition.

More males than females died in each category, except for homicide where the numbers were equally distributed between genders.

Figure 8. How did these children and youth die? (N = 558)



Approximately 50% of non-aboriginal deaths were as a result of accidents (as illustrated in the top of Figure 9), whereas in the aboriginal population "accidents", though still the most prevalent cause of death, only accounted for approximately thirty percent of the child and youth fatalities. A high prevalence of SIDS in the aboriginal population lead to its being ranked a close third as the most common classification of death in the aboriginal population.

Figure 9. Was the classification of death different for Aboriginal children and youth?
n = 553

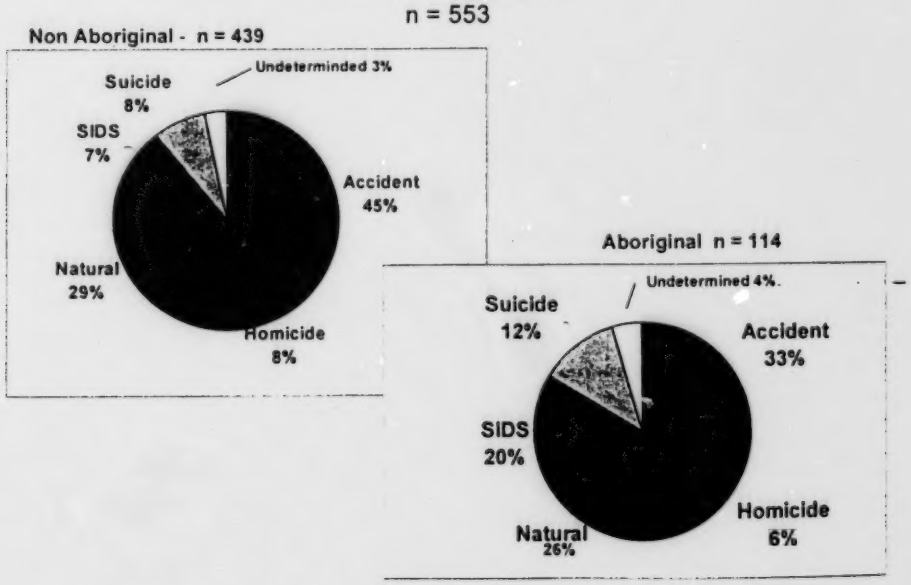
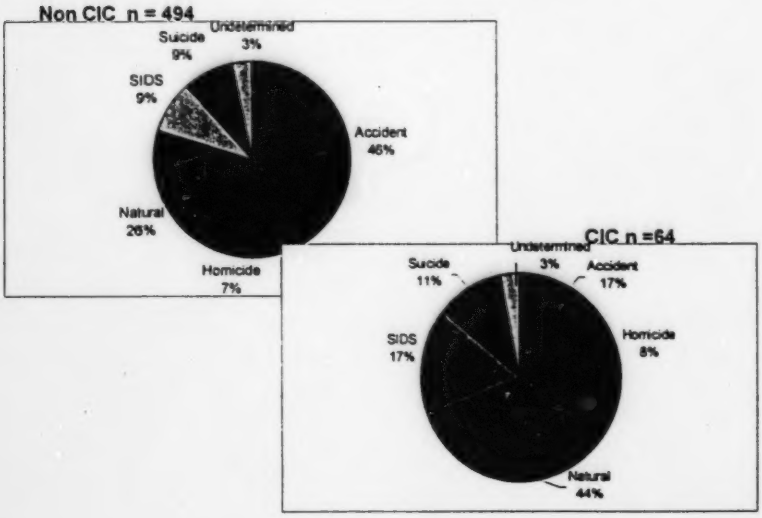


Figure 10 compares the major causes of death for children in care as compared to those not in care. For children not in care, accidents were the most prevalent cause of death, compared to CIC where natural deaths were the most common. Double the percentage of suicides and SIDS were found in the CIC group as compared to the non CIC group. However, it is important to note that the total number of CIC was relatively small and that many children are in care because they are medically fragile and may need highly specialized care (A Report on the Health of British Columbians, 1997).

Figure 10. Was the classification of death different for children in care? N = 558



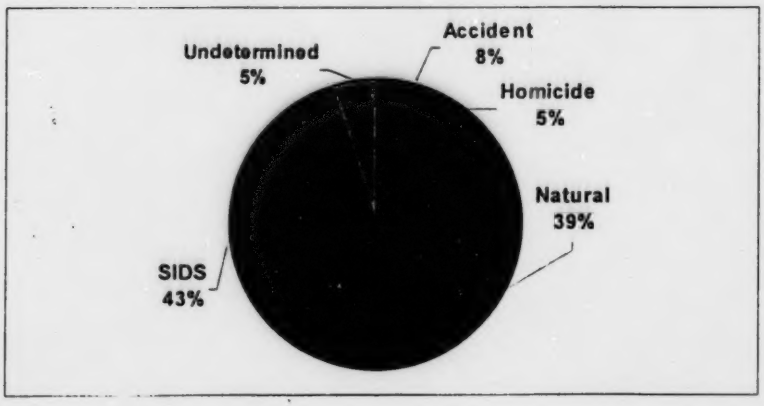
How did the children in various age groups die? SIDS and natural causes were the leading classifications of death in the 0-4 year age group (Figure 11). After age 4, accidents were found to be the main cause of death. Two thirds of deaths in children aged 15-18 occurred as a result of accidents, with the most common accident being the motor vehicle.

Figure 11. How did the children in different age groups die? (N=558)

Figure 12 presents the classifications of death for children under the age of one. Almost half of these deaths were classified as SIDS deaths, while almost 40% died as a result of natural causes.

Figure 12. How did the children under the age of one die?

(n = 122)



C) Alcohol Use

The information in Table 1 on the presence of alcohol in the lives of children and youth is divided into three main sections. "Any alcohol use" (highlighted in yellow) is defined as alcohol being mentioned anywhere in the report, while "personal current alcohol use" (highlighted in blue) indicates the deceased child was under the influence of any amount of alcohol at the time of their death. "External current alcohol use" (highlighted in green) represents instances where someone external to the deceased child at the scene of the death was under the influence of any amount of alcohol. (Note: the information contained in this table needs to be interpreted with caution since the numbers of fatalities in some categories are small.)

Across all three categories in Table 1, alcohol is most commonly present in the 15-18 year old group.

In 30% of deceased children aged 0-4 years reference is made to the impact on the child by someone else's alcohol misuse.

Table 1. Which age categories were the most influenced by alcohol in their lives?

Age Category N = 558	# of files with any alcohol use (yes/likely)	%	# Personal current alcohol use	%	# External current alcohol use	%
0 – 4 years n = 193	58	30%	0	0%	9	
5 – 9 years n = 69	17	25%	0	0%	8	
10 – 14 years n = 86	22	26%	4	5%		
15 - 18 years n = 210	117	56%	72	34%	52	

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15 - 18 years n = 210	117	56%	72	34%	52	25%

Table 2. provides information on the presence of alcohol among the differing age groups for children in care. Alcohol was mentioned in almost two thirds of the CIC reports for 10 – 14 year olds and in approximately four out of five of CIC reports for youth aged 15 – 18 years.

Almost half of the investigated youth fatalities between 15 – 18 years of age were drinking at the time of their death.

In the youngest two age groups there was no reported personal or external current use of alcohol at the time of the death.

Table 2. Alcohol in the lives of children in care.

Age Category N=64	# of files with any alcohol use (yes/likely)	%	# Personal current alcohol use	%	# External current alcohol use	%
0 – 4 years n=28	15	54%	0	0%	0	0%
5 – 9 years n=3	0	0%	0	0%	0	0%
10 – 14 years n=11	7	64%	1	9%	1	9%
15 - 18 years n=22	18	82%	12	55%	5	23%

The presence of alcohol was profound in the death of aboriginal children. Table 3 demonstrates that alcohol was found to be involved in the lives of more than fifty percent of the child fatalities aged 0-4, sixty-five percent of those aged 10-14, and over eighty percent of those between the ages of 15-18 (highlighted in yellow).

More than half of the youth between the age of 15-18 were drinking at the time of their death (highlighted in blue), and about one third were in circumstances where others were drinking (highlighted in green).

Table 3. Alcohol in the lives of Aboriginal children and youth.

Age Category N=114	# of files with any alcohol use (yes/likely)	%	# Personal current alcohol use	%	# External current alcohol use	%
0–4 years n=53	30	57%	0	0%	4	8%
5–9 years n=7	3	43%	0	0%	1	14%
10–14 years n=15	10	65%	4	27%	3	20%
15 - 18 years n=39	34	87%	21	54%	11	28%

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Age Category N=114	# of files with any alcohol use (yes/likely)	%	# Personal current alcohol use	%	# External current alcohol use	%
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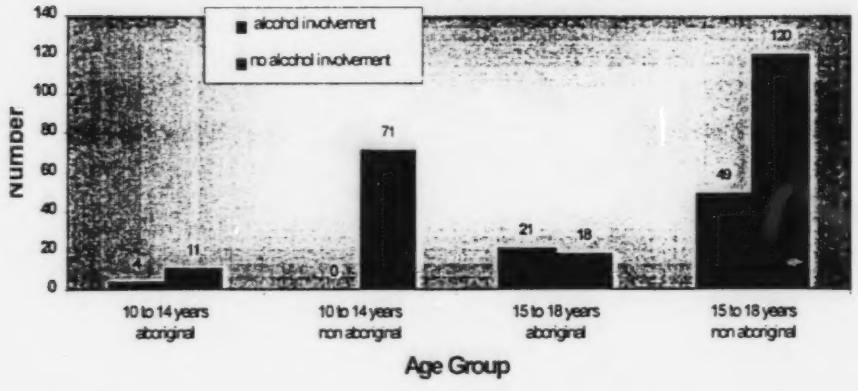
5–9 years n=7	3	43%	0	0%	1	[illegible]
10–14 years n=15	10	65%	4	27%	3	[illegible]
15 - 18 years n=39	34	87%	21	54%	11	[illegible]

Figure 13 presents the differences between aboriginal and non aboriginal youth (ages 10-14 and 15-18) in terms of whether the youth were drinking alcohol at the time of their death. Alcohol use begins earlier in the aboriginal group - appearing already in the 10-14 year old age group. It is also more prevalent in the aboriginal 15 –18 year old age group than in the non-aboriginal 15 –18 year group.

Figure 13. Is personal current alcohol involvement more prevalent in Aboriginal as compared to Non Aboriginal groups?

(N=296 Two fatalities of unknown origin not included)



D) Evidence of FAS/pFAS or prenatal exposure

In reviewing the 558 fatality investigations 4% of the files mentioned FAS or p/FAS and 5% mentioned that the mother of the deceased child drank while she was pregnant (Figure 14.). We recorded that the mother drank while pregnant if there was any mention of alcohol intake by the mother during her pregnancy. This was recorded as alcohol "exposure" unless FAS or p/FAS was also mentioned in the file, in which case it was recorded as FAS/pFAS.

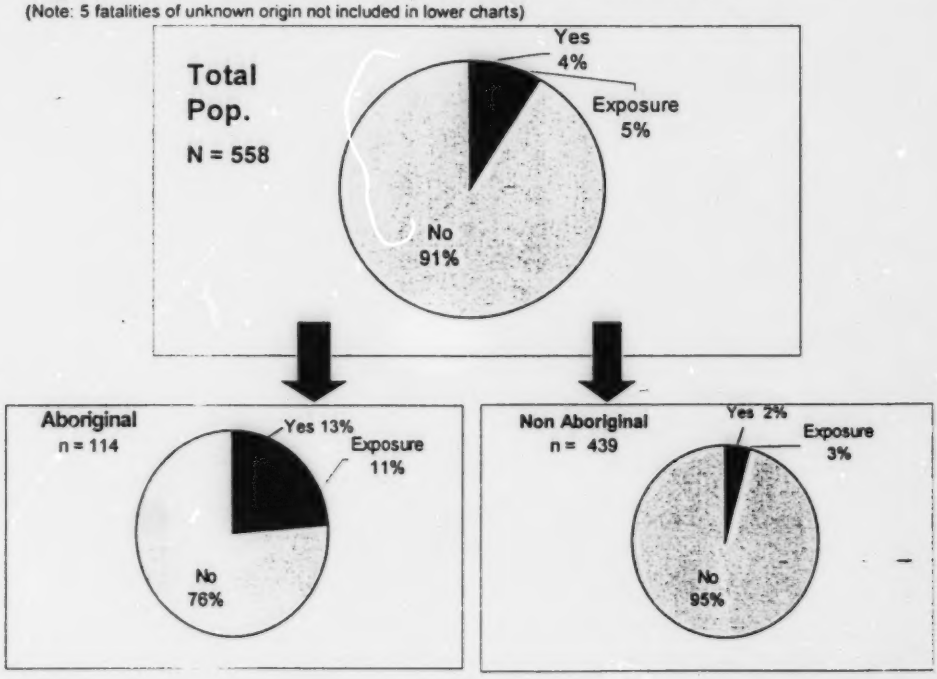
Prenatal alcohol exposure was defined in this way for several reasons. If a report made reference to alcohol, heavy use or abuse of alcohol had occurred. As well, it is unknown whether safe quantities of alcohol can be consumed during pregnancy. FAS/pFAS may occur because of regular moderate to heavy drinking throughout pregnancy or as a result of occasional binge drinking. Other factors such as parental health, nutritional status, tobacco use, other drug use, violence, history of obstetric problems, lack of prenatal care, lifestyle and socio-economic factors are associated with increased risk.

A total of 47 or 9% of the entire child fatality population reviewed by the Commission had been exposed prenatally to alcohol.

Of the 114 aboriginal children who were subjects of these reports, 13% had FAS mentioned in their file, while 11% indicated that the mother of the deceased child had consumed alcohol during her pregnancy. This compares to 2 and 3% respectively for the non-aboriginal population.

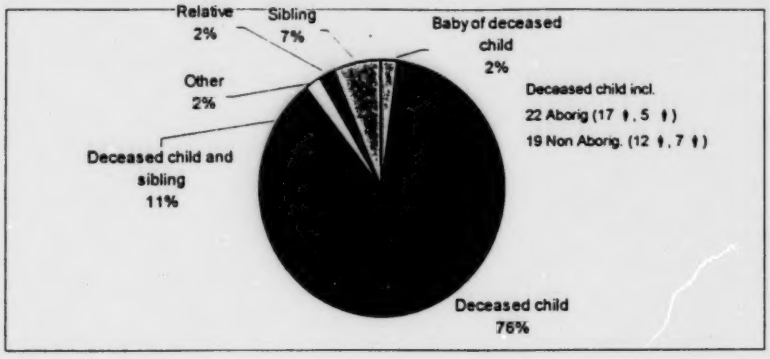
Figure 14. Was FAS mentioned in the file?

(Note: 5 fatalities of unknown origin not included in lower charts)



In more than 85% of the reports, in which prenatal alcohol use was mentioned, it was the deceased child who exhibited FAS/pFAS or exposure to alcohol. Of these 41 deceased children and youth, 22 were Aboriginal and 19 were non-aboriginal.

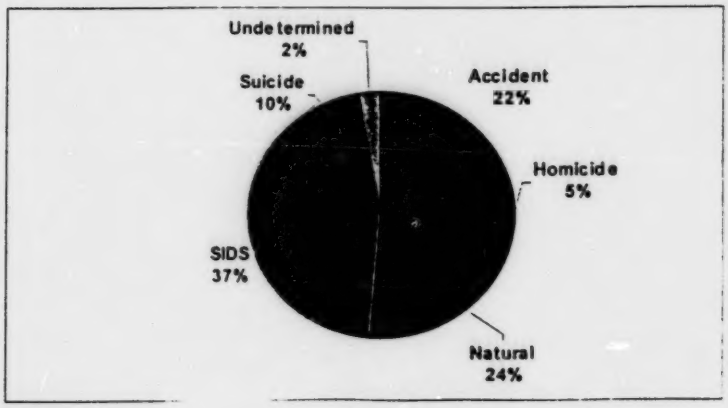
Figure 15. Who was affected by FAS/pFAS or exposure to alcohol?
n = 47



Sudden Infant Death Syndrome was the most commonly reported way in which these children died and accounted for 37% of deaths for children that had prenatal alcohol exposure, followed by natural causes, which accounted for 24% of deaths.

Figure 16. How did the children exposed to alcohol prenatally die?

n = 41



FAS and p/FAS can have devastating effects on children's lives. This is illustrated in the following case profile:

PROFILE 1. The effects of prenatal alcohol exposure

This child experienced an extensive history of physical abuse and neglect due to his mother's and her partners' alcohol misuse. His mother was known to drink heavily even while she was pregnant and he was considered to suffer from the effects of fetal alcohol exposure.

The child was placed with a number of other relatives to be cared for but all apparently had the same dysfunctional home environment consisting of chronic alcoholic usage and volatile personalities. This youth's own personal alcohol and drug problems started at an early age and he is said to have experienced his first alcohol induced blackout at age ten. He started stealing, engaging in violence and accumulating various criminal charges. Finally his family were no longer willing or able to provide him with a home due to his own severe alcohol abuse. At this point he was removed by MCF.

He spent the last three years of his life in numerous foster homes, group homes, alcohol treatment facilities, on the street and occasionally with family. His use of alcohol, abusive behavior and criminal activity continued to increase . He had a history of depression, which was exacerbated, when he drank alcohol.

On the night that he died he had spent the evening, in a suite that he shared with his two friends, listening to music. He had been very depressed and indicated that no one loved him. In the early morning hours he attended a party at a nearby house where he stayed for about half an hour before returning home. Shortly after leaving he committed suicide in his own home.

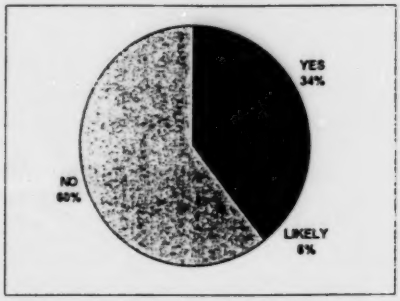
E) Classifications of Death

1) Motor Vehicle Accident

Of the 139 motor vehicle accident fatalities that were reviewed, alcohol was present or likely present at the time of death in 40% of cases. Alcohol involvement was recorded if the toxicology report indicated positive alcohol use (of any blood level of alcohol). "likely alcohol use" was noted if there were positive indicators but no toxicology report and included examples such as: beer cans found in the car; youth seen by witnesses to be drinking; youth known to be with others that were drinking and their history was highly suggestive; or police smelled alcohol on the breath. We recorded "no" if there was no reported alcohol use, or the toxicological reports were negative or there simply was no evidence of alcohol use.

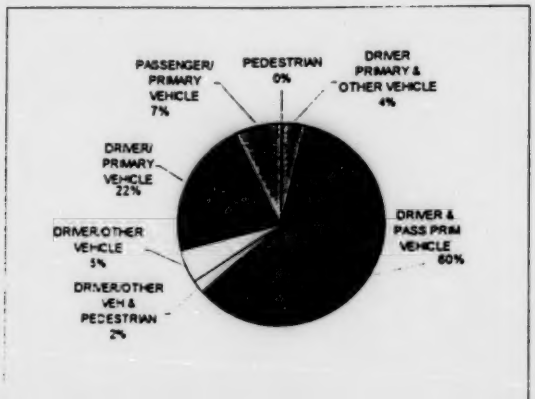
Figure 17 presents the percentage of motor vehicle accidents where children or youth died in which alcohol use was a factor.

Figure 17. In what % of deaths was a motor vehicle and alcohol involved? n = 139



In 83% of 55 MVA fatalities involving alcohol the driver of the primary vehicle (the deceased was a passenger) had consumed alcohol (as noted in blue lettering in Figure 18). In 60% of cases, both the driver and passenger of the primary vehicle had been drinking. In only 11% of the cases was the driver of the other vehicle drinking.

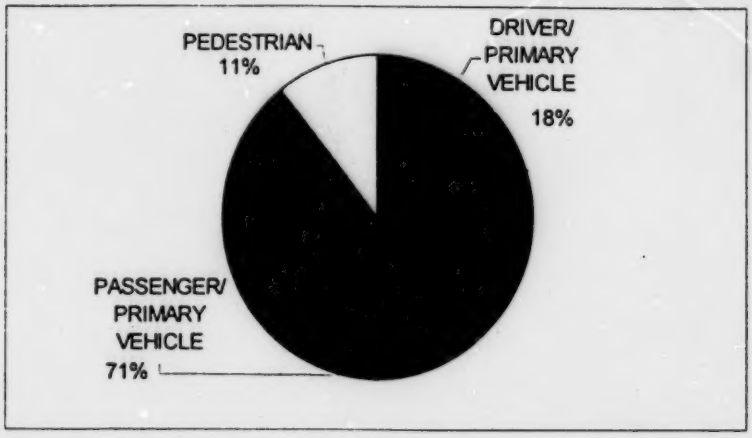
Figure 18. For MVA's, who used alcohol?
n = 55


PASSENGER/ PRIMARY VEHICLE 7%
PEDESTRIAN 0%
DRIVER PRIMARY & OTHER VEHICLE 4%
DRIVER/ PRIMARY VEHICLE 22%
DRIVER & PASS PRIM VEHICLE 60%
DRIVER/OTHER VEHICLE 5%
DRIVER/OTHER VEH & PEDESTRIAN 2%

In 72% of the MVA fatalities involving alcohol, the deceased child was a passenger (Figure 19). While it is more likely that the driver of the primary vehicle is drinking, it appears that the passenger is more likely to die.

Figure 19. Where was the child who died?

N= 55 (36 males and 19 females)



The prevalence of alcohol-impaired driving and the mortality resulting from this continues to be a major area of concern. Alcohol remains the most important preventable cause of motor vehicle related deaths. This factor has been taken into account in more recent years when planning graduation celebrations involving high school students. However, as portrayed in the following case profile, plans can go astray.

PROFILE 2. The effects of alcohol when combined with motor vehicle use

A pre-graduation party had been organized on a private property where over 250 youth would be attending. Parent chaperones were on the property and the plan had been for everyone to stay overnight. Alcohol was consumed at the party. By early morning there was only one chaperone left and the 30 to 40 remaining youth were asked to leave when a fight broke out. Two of the boys then drove to a nearby community to have breakfast at a local restaurant. They were refused service because of their intoxicated state. Driving back to their hometown, these two seventeen-year-olds were killed instantly in the early morning hours when their vehicle collided with an oncoming truck. The driver had a blood alcohol level of .21 and the passenger had a blood alcohol level of .12.

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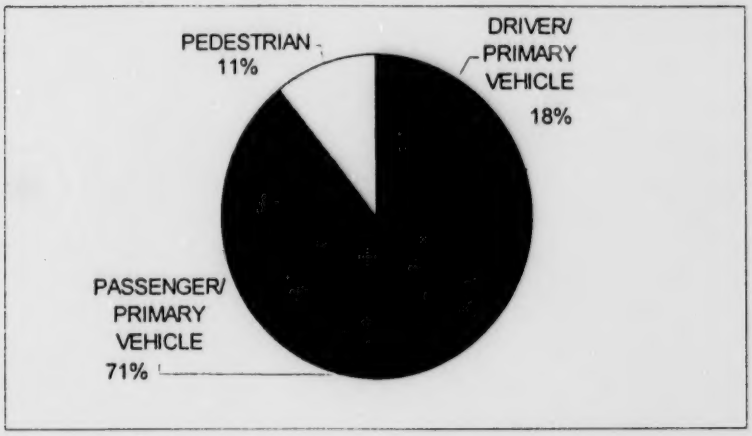

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2) Drowning

Of the thirty-three drownings studied, nine (27%) involved alcohol being consumed by someone at the time of the child or youth's death. Of these nine drownings, five were male while four were female, eight involved youth who were above the age of 16, and in eight cases the person who drowned had been drinking at the time of their death.

None of the children and youth in the overall sample (n=33) were wearing personal floatation devices at the time of their death.

Individuals who are intoxicated are more likely to boat or swim in dangerous circumstances, to fall into the water, or be less able to get out of the water as compared to persons who have not been drinking. Although in many cases it was the youth who died that had been drinking alcohol, in 7 out of 9 cases others had been drinking as well.

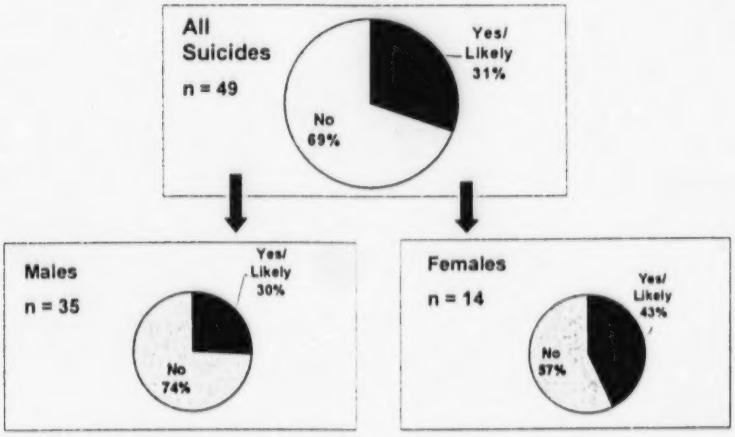
PROFILE 3. Alcohol and recreational swimming

An 8 year old child was swept away by the swift current of a river while being supervised by her mother and her mother's friend. Both adults had been drinking during the course of the afternoon. The adult friend attempted to rescue the child, but attempts were unsuccessful. She went to a nearby community to seek help, while the mother remained at the scene. The adult friend was later discovered at a friend's home where she was consuming more alcohol. The following morning, police found the adult friend to be intoxicated, and upon transporting her by police car, she stated that she need to bring a can of beer with her for the drive.

3) Suicide

Suicide was found to be more prevalent in the older adolescent and more common among males than females. Approximately one third of all the children that committed suicide were under the influence of alcohol at time of their death (Figure 20).

Figure 20. What percentage of of persons who committed suicide were under the influence of alcohol?



4) Homicide

Since October 1996, 41 reviews of cases of children and youth who died as a result of homicides have been completed. In 4 of the cases (approximately 10%) alcohol involvement was present at the time of their death. In all four cases the child who died as well as the perpetrator were using alcohol at the time of the child's death.

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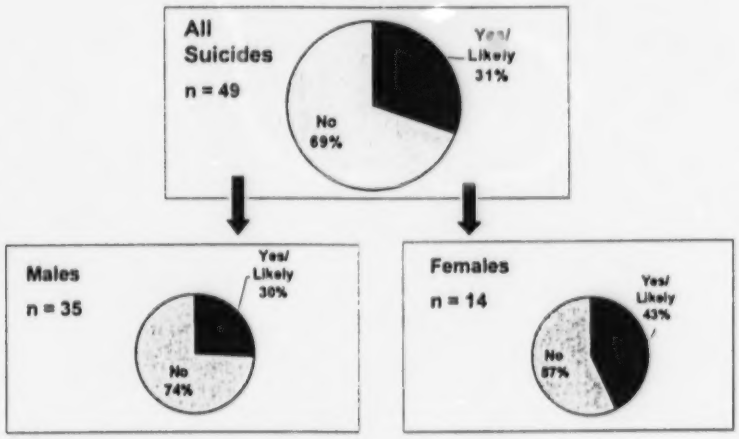

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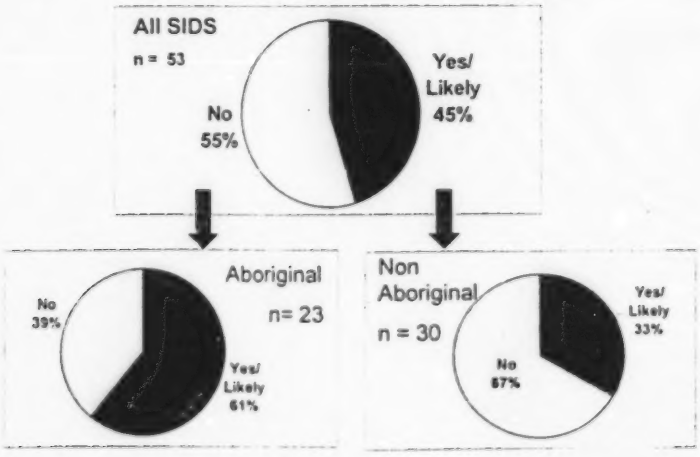
Profile 4. Alcohol and homicide

A 15 year old girl was found dead two months after she had been stabbed to death. It was suspected at birth that she was affected by FAS. Her parents and grandmother were all heavy drinkers, and she was physically abused. She was thrown against the wall during one bout of drinking. Permanent custody was given to a relative. By the time she was 15, she was violent, suicidal, addicted to cocaine, and abuse of alcohol was a long standing pattern. And she was unreachable by the types of services traditionally available to youth - these programs could not engage her. She was being exploited in the sex trade, and it is thought that she was killed by a customer.

5) Sudden Infant Death Syndrome (SIDS)

Of the 53 deaths classified as SIDS deaths, alcohol involvement was found in 45% of cases. Of the aboriginal children who died of SIDS, alcohol was mentioned in 61% of the files as compared to 33% of the non-aboriginal children who died from SIDS.

Figure 21. In what percentage of SIDS cases was alcohol misuse mentioned?



6) Summary of Findings

In summary, how prevalent is alcohol in the lives and deaths of the children and youth we investigated? In terms of their lives: it was present in almost 2/5 of the lives of children who died in motor vehicle incidents, and an equal proportion of SIDS, and homicide deaths, in almost ¾ of suicides, and in almost 1/3 of drownings.

Approximately half (45%) of the cases we reviewed mentioned alcohol within the lives of these children and youth. In other words, in almost half of the reviews alcohol was being misused at the time of death, or was misused in the past either by the deceased individual or someone closely associated with the individual.

Table 5. How prevalent is alcohol in the lives and deaths of children?

Cause of Death	Total #	Alcohol mentioned in the fatality report (yes/likely)		Alcohol present at time of death (yes/likely)	
		Number	%	Number	%
Motor Vehicle Accident	139	55	40%	52	37%
Suicide	49	34	69%	15	31%
SIDS	53	24	45%	4	8%
Homicide	41	20	49%	4	10%
Drowning	33	9	27%	9	27%
Total/Mean	315	142	45%	84	27%

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V. Children's Commission Recommendations - Alcohol Related

In 19 fatality review reports, the Commission made findings that resulted in 25 alcohol-specific recommendations being made.

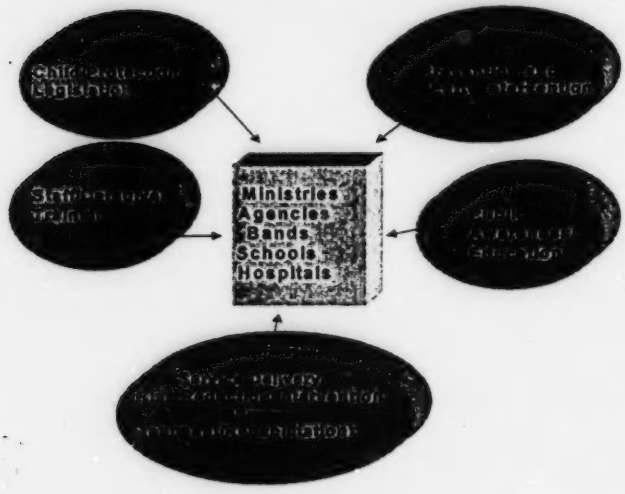
The findings from these 19 fatality reviews were focused on some aspect of legislation, training, policy, prevention or intervention and awareness that was found to be lacking in the review of the services and supports in place for these youth during their lives, and at the time of their deaths.

The Commission's alcohol-specific recommendations fall into five broad groupings (refer to Figure 21)

1) Child Protection/Legislation
2) Prevention and Early Intervention
3) Staff/Caregiver Training
4) Public Awareness/Education
5) Program/Service Delivery

These recommendations have been made at both the case-specific and systemic level and have been sent to Ministries, Agencies, Bands/Tribal Councils, Schools and Hospitals

Figure 21. Grouping of Children's CommissionAlcohol Specific Recommendations (25 Recommendations)



A) Child Protection/Legislation (1 recommendation)

Recommendation:	Response
• MCF encourage social workers to consider obtaining and then monitoring compliance with a court order prohibiting consumption of alcohol and/or requiring participation in drug/alcohol treatment and counseling services, by the care giver, when it can be shown that children have been neglected or harmed due to a history of alcohol abuse by the care giver.	• The ministry introduced an amendment to the Child, Family and Community Service Act that would allow a Supervision Order to be granted without the child first being brought into care. If a caregiver's alcohol consumption was an identified problem, as was the case in this fatality review, abstaining from alcohol can now be recommended to the court as a condition.

B) Prevention and Early Intervention (2 recommendations)

Recommendation	Response
• Research into the needs and service implications for children with Fetal Alcohol Syndrome (FAS), and the need for the Ministry for Children and Families (MCF) and other child serving ministries and agencies to develop a coordinated approach to prevention and early intervention regarding alcohol abuse.	• MCF funded a number of research projects in this area, which were completed and made available to the public. The Ministry has been working on the provincial strategy to address the needs of those impacted by FAS, and women at risk. Provincial strategies as well as inter-ministerial and community based participation measures attempting to improve the level of coordination in alcohol abuse prevention and early intervention.

C) Staff/Caregiver Training (4 recommendations)

Recommendations	Responses
• Systemic training recommendations to the Ministry of Education (MOE) and MCF regarding training on the early recognition and service implications of FAS, and also on the ongoing need for training and outreach to foster parents who are care giving infants who have been exposed to alcohol during gestation.	• The MOE has developed resources for teachers to assist them with recognizing, teaching and managing students with FAS.
• Case-specific recommendations to particular Bands and agencies regarding the need for training in the signs and symptoms of alcohol abuse and other risk factors.	• MCF has developed training plans, held in-services and provided additional training for caregivers working with children and families with FAS.

D) Public Awareness/Education (5 recommendations)

Recommendation	Response
• The Commission emphasized the need for increased public education and awareness of the often-fatal effects of combining alcohol with water-based recreational activities, driving or other drugs and directed these recommendations at ICBC, the Red Cross and School Districts.	• All of the recommendation recipients have actively worked to increase the level of awareness of youth as well as the general public of the increased risks associated with combining alcohol with activities that require judgement, coordination or multi-tasking.
	• Initiatives have included media campaigns (television, print, radio, etc.), school presentations and targeted training/educational materials, such as those directed at young male boaters and new drivers.

E) Program/Service Delivery (13 recommendations)

Recommendation

- Address issues of access, availability and suitability of treatment programs, addiction services, post-discharge services and supports for FAS infants and their mothers, counseling services for youth and women and the need for more culturally appropriate services for aboriginal youth and families and more timely services for FAS youth involved with the justice system.
  Recommendations have been addressed to MCF, Ministry of Health (MOH), Ministry of Attorney General (MAG), Hospitals and Bands.

Responses

- Activities have ranged from local, inter-ministerial/inter-agency reviews of current services to reviews and strategic developments that provide a provincial perspective to help ensure the overall needs of a particular population are being fully considered.

- Other responses have focused on the specific responsibilities of multidisciplinary team members in ensuring that clients have appropriate community support networks in place while working on alcohol addiction rehabilitation or when supporting substance-using mothers after hospital discharge. Use of a multi-risk model that accounts for pre-natal alcohol (drug) exposure, the medical status of the mother and the care giving environment of the infant has been established through the development of Discharge Planning Guidelines for High Risk Infants.

- In one region, a variety of projects have occurred in partnership with Aboriginal groups. Within this region alcohol drug treatment programs have been established and an alcohol and drug worker has been hired.

VI. Key Findings and Policy Implications

This study supports the findings of other research studies that concluded that fatalities, unintentional and intentional, associated with alcohol use in the child and youth population represent one of the leading preventable causes of death among this age group (Cummings & Quan, 1999; Quinlan et al., 2000; Margolis et al., 2000). Key findings of this report indicate that alcohol has a profound presence in the lives and deaths of the children and youth the Children's Commission has reviewed. For example:

- Alcohol was present at the time of death in 2 out of 5 motor vehicle deaths, and 1/3 of suicides and drownings, and played an important role historically in the lives of many of the cases we reviewed.

- Motor vehicle incidents continue to take many young peoples lives. While it is most often the driver of the primary vehicle that is drinking, it is the passenger of that vehicle who is most likely to die.

- Prenatal exposure to alcohol occurred in of approximately 1 in 10 cases we reviewed. Approximately 37% of deaths for children who had prenatal alcohol exposure, were classified as SIDS deaths.

- The impact of alcohol among children in care as well as Aboriginal children and youth is particularly profound. The impact occurs earlier, and it is associated with tragic outcomes.

Alcohol has been identified as the most widely used psychoactive drug in the world (Guohua, 2000). While its availability and use are subject to controls in our society, it is undeniably a visible and acceptable part of our culture and frequent exposure cannot be avoided (Addition Research Foundation, 1996). Most adults drink, and most do so responsibly.

Within this context however, our society has tended to over-look some of alcohol's adverse effects. The consequences of inappropriate use of alcohol are poignantly illustrated throughout this report. The magnitude of the numbers of children and youth whose deaths are related to, or whose lives have been touched by the misuse of alcohol is clearly astonishing.

The implications of the findings outlined in this study are many and varied Following are strategies that exemplify the kinds of actions that could begin to address the magnitude of this problem.

- **Comprehensive Community Programs** - Complex societal issues require multiple strategies. Communities need to embrace a culture of prevention and early intervention, to increase the public's awareness of the risks associated with alcohol misuse and risky environments and to ensure that programs are sufficiently funded and sustained in order to bring about needed change. Prevention programs need to consist of multiple strategies including those that are universal (designed to address the general population), selective (targeted at at-risk groups) and indicated (targeted at individuals who already demonstrate the problem behaviour). "Substance abuse among children is a complex, multi-factorial-challenge that requires consistent and unremitting attention" and action (Johnson, 1997).

  Adolescents use alcohol for a multitude of reasons including partying with peers, and attempting to deal with personal problems.. Schools and communities can foster alternative choices that are

attractive to youth and provide them with the experiences conducive to healthy maturation.

- **Adult Modeling Behavior** - As seen in this report, adult's behaviors in relation to alcohol can dramatically elevate the risk to their children (eg. FAS/pFAS and MVA's). All adults have an important role in teaching young people about the dangers of inappropriate alcohol use and ensuring that they set a good example.

- **Deterrence Laws** include strategies to specifically deter individuals from drinking and driving with children in the vehicle. For example lowering legal blood alcohol limits from the current .08% BAC to .05% BAC for drivers transporting children.

- **Alcohol Control Policies**. Alcohol, like tobacco is "price-elastic". In other words, increasing the price slightly can have a profound impact on the prevalence of drinking among adolescents who purchase alcohol (Margolis et. al., 2000; Grossman et. al., 1994).

- **Increasing Public Awareness**. Messages such as "don't drink and drive" and increased enforcement have clearly had an impact on the numbers of drivers who drink. Being a "designated driver" has become socially acceptable. However, even with a sober driver, automobiles loaded with intoxicated passengers are at greater risk of being involved in a motor vehicle incident. Every opportunity should be taken to educate the public about responsible use such as posters in drinking establishments, server intervention initiatives and information labels on beverage containers.

- **Addressing Needs of Unique Population**. Attempts to address the needs and capacities of adolescents requires the recognition that "youth" does not represent a homogenous group, but rather a special population. Unique groupings within the youth population include: social /demographic groups such as "street kids" or high income kids with fast cars; age - from children to almost adult; groups at risk as a result of psychosocial problems such as attention deficit disorder or depression; or cultural or ethic groups such as Aboriginal youth. Communities need to be supported in developing strategies to address the disproportionate impact that alcohol can have among these unique groups and every opportunity should be taken to include youth in the identification of issues and planning of initiatives. Communities need to reach out the youth, involve them in meaningful ways in identifying solutions, and provide them with an ongoing voice.

- **Aboriginal Children and Youth.** The impact of alcohol misuse on the health, well-being and safety of aboriginal children and youth is particularly concerning. Aboriginal communities should be supported in identifying the underlying causes of alcohol misuse and in planning, developing and implementing their own strategies and solutions.

- **Speaking Out**. Our data indicate that lives could have been saved if someone had intervened. Being passive, not wanting to become involved, or fearing that someone might be offended prevents many persons from speaking out or taking appropriate preventive action. A mindset of "it's only alcohol" creates a complacency that can overshadow the potential risks that exist. However, community acknowledgement of risk factors, commitment to action and ensuring youth are connected to community organizations, provide protective factors to shield children and youth and enhance their resilience.

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